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ENDOMETRITIS: HOW FREQUENTLY A CAUSATIVE FACTOR IN DYSMENORRHEA.

BY FLORENCE N. WARD, M. D.

As dysmenorrhea is the chief pelvic disturbance among yound and unmarried women who come to the gynecologist for relief, it is a subject demanding most careful investigation and study. Authoritative knowledge of this distressing condition is to-day in a most unsatisfactory condition. No two authors agree as to the ætiology, pathology, or methods of treatment. Old pathological theories are being dropped, accepted classifications denied, and established lines of treatment disproved.

The old classification of ovarian, obstructive neuralgic dysmenorrhea in practical clinical work is neither correct nor comprehensive.

I have seen cases of so-called ovarian dysmenorrhea, characterized by pain in one or the other ovarian region, to have no ovarian disease whatever. Examination under an anæsthetic showed both ovaries normal, and the pathological condition to be resident within the uterus. A still further proof of the correctness of the diagnosis was the disappearance of the dysmenorrhea under the treatment directed to the uterus.

The obstructive theory is not correct, as proven by the failure of treatment directed upon that line. In spite of dilatation and splitting of the cervix, absolute failures repeatedly occur. The wearing of stem pessaries to maintain the patency of the canal carries with it such grave danger of septic inflammation with possible extension to the appendages, that such method has been discarded.

The term neuralgic dysmenorrhea is a loose and vague division that is probably meant to include all cases that cannot be comprehended in the other two. With better understanding of the conditions prevailing, and with more accurate diagnosis, so-called neuralgic dysmenorrhea will rarely be seen.

Profiting by failures in the past, having unlearned old pathological theories, we are ready to solve the problem of better methods.

Dysmenorrhea is essentially the disease of the young woman, just as lacerations, displacements, and peri-uterine inflammation are the diseases of the matron. After careful clinical observation I have come to the conclusion that in the great majority of cases the seat of the trouble is to be found in the uterus itself, and upon the endometrium of the uterus is manifest the tangible or organic change that signalizes constitutional disturbance or dyscrasia within the girl's body.

How frequently has it occurred that a young girl has been brought to me suffering with dysmenorrhea. Her history shows a constant tendency to sore throat, pharyngitis, or tonsilitis through childhood, a diminished tendency to such diseases after the inauguration of menstruation, but a severe type of dysmenorrhea is then manifest. Pelvic examination shows a normal condition of the appendages, but a profuse discharge pouring from the cervix, an erosion of the external os, and on passing the sound an exquisite sensitiveness of the endometrium. So frequently have I observed this relationship between inflammatory or catarrhal conditions of the throat and endometrium that it is not an accidental coincidence; and furthermore, more evidence shows that endometritis starts from within, as in no case has there been evidence of extension from without any bacterial invasion, there being no vaginitis, and the hymen is generally intact.

The investigations of Warbasse, who has made a careful

study of the bacteriology of chronic endometritis, is most pertinent at this point. From a study of a large number of cases, Warbasse draws his conclusions that it is no more necessary to seek for a microbic origin in chronic endometritis than in chronic degeneration of any of the glandular organs. The glandular portion of the uterus is made up of secreting epithelial cells resting upon a connective tissue stroma, just as in the kidney, liver, or the breast.

Either of these elements may become changed or increased through irritative or trophic changes without the presence of bacteria. The next step is to discover the function of this glandular structure, or endometrium. J. H. Keiffer has studied its physiology and comes to the conclusion, as the result of experimental research, that the function of the epithelial tubes of the uterine mucous membrane is not limited exclusively to the production of the secretion for the cavity of the uterus suited to its special reproductive function. There is a decided chemical alteration in the menstrual blood, and he maintains that the uterine epithelium acts here like a kidney glomerule, and that urine passing the one is analogous to albumin passing the other. The menstrual process Keiffer holds acts in two ways: preparing for the maturation of germinative elements and exciting genetic activity on the one hand, and on the other eliminating from the organism certain products of secretion that, failing their direct biochemical application in reproduction, must be rapidly discharged. If this elimination fail, if these products are not utilized or gotten rid of, they acquire a toxic property, and their absorption gives rise to the disturbances of the nutrition and the derangement of systemic equilibrium that we observe as the effect of disordered or suppressed menstruation. The endometrium of the uterus thus acts throughout reproductive life as an excretory organ, eliminating toxic products in its function of menstruation.

By thus realizing the complexity of the physiological processes that take place in the endometrium, we can readily understand how easily disturbances of functional activity may take place by sudden cold, overexertion, nervous shock, or strain, and even organic changes as the result of constitutional conditions of the patient such as a lithæmia or neurasthenia. If the glandular structure is involved, the menstrual blood is

not chemically altered as it passes through the tubules, and it retains its fibrine, permitting it to clot and distend the uterus, until by its own pressure and with much pain it dilates the cervix and escapes. Or the connective tissue of the endometrium may become hyperplastic, offering an obstruction to the free action of the glandular structure. This form is manifest in the so-called membranous dysmenorrhea. Viewed from this standpoint, the failure to relieve dysmenorrhea by a simple dilatation or splitting of the cervix is not hard to understand. As rational would it be to dilate the pelvis of the kidney to cure a nephritis.

Jung's and Bosse's investigations on the removal of the endometrium after curettage are most interesting. They prove that the endometrium is a tissue possessing an inexhaustible power of regeneration, no matter how thoroughly it may be destroyed. Microscopic investigation by Werth shows that young connective tissue is renewed within a few days after traumatism from similar tissue in the muscularis. The glands develop from remnants of pre-existing glands, the superficial epithelium from that lining the mouths of the newly formed glands, but on examination the new mucosa was in the same hyperplastic condition as before the cauterization.

The uterus in the virgin being rigid, hard, and unyielding, it adapts itself but poorly to inflammatory thickening of its interior. The reason for the relief of dysmenorrhea following childbirth is that the uterine body is not so unyielding as in the virgin state, the cervix remains more open, and the cavity is larger, allowing greater space for a thickening endometrium if the endometritis has not been perfectly cured.

The treatment that I have most successfully caried out has been, in acute cases, the indicated remedy, and, in those patients subject to throat affections the same remedy that controls the pharyngitis controls the endocarditis—bell., guaicum, mercur., and puls. The local treatment consisted in soothing applications, such as hydrastis, ichthyol, or boroglycerin, on small vaginal tampons carefully applied. During the acute process intra-uterine treatment is too painful, besides to my mind a dangerous procedure—the inflammatory process is apt to be spread through the appendages, which is an accident much to be deplored. The constitutional condition is most

carefully studied, diet regulated by avoiding excess of nitrogenous and saccharine foods. The eliminative processes are particularly controlled, that no auto-intoxication goes on, freedom from nervous strain is imposed, and much rest is required during the day, beside long hours of sleep at night.

The degree of surgical care required depends upon the case. In many cases none at all, particularly recent ones. In case there is a long, hard, unyielding, poorly developed cervix, after the inflammatory condition has been controlled, dilatation is carefully practiced, under aseptic precautions, by graduated sounds.

In the old cases, where the hyperplasia of the endometrium is marked, or membranous dysmenorrhea exists, cureftage is a valuable step in the treatment. By this means inflammatory products are gotten rid of, and better drainage insured.

Finally the selection of the deep-acting constitutional remedy according to the individual peculiarities. In no disease is individualization more necessary.

In young girls with a tubercular tendency, or with a bad heredity, great care should be exercised in treating locally an endometritis that may exist. If microscopical examination reveals the presence of tubercle bacilli, I would advise letting it alone locally, and depending entirely upon remedies and general hygienic measures. They are cases peculiarly intolerant to local interference.

One case that came under my observation produced a most vivid impression. A young girl had been under local and general care for many months with a most intractable form of dysmenorrhea and endometritis. Her physician gave her a thorough dilatation of the cervix. She went home, had a pulmonary hemorrhage, and rapidly developed pulmonary tuberculosis, which ran its course in a few months. She has evidently had a primary tubercular endometritis.

The conclusions to be drawn are:

1. Simple or primary endometritis is not a bacterial disease, but a glandular inflammation of the endometrium.
2. Clinical experience shows that in the large majority of cases dysmenorrhea in young women is caused by endometritis.
3. Absolute inadequacy of treating dysmenorrhea and the coexisting endometritis by purely mechanical measures.
4. The constitutional nature of dysmenorrhea and, consequently, the necessity for the carefully indicated remedy.